STATE OF MARYLAND
DEPARTMENT OF HUMAN SERVICES
FAMILY INVESTMENT ADMINISTRATION

PUBLIC ASSISTANCE TO ADULTS DISABILITY CERTIFICATION FORM

Public Assistance to Adults is a monthly payment of State funds to an individual who has been certified for a licensed assisted living program, a CARE home, or a Department of Health and Mental Hygiene (DHMH) rehabilitative residence.

SECTION I REPRESENTATIVE PAYEE'S AGREEMENT

In becoming a Representative Payee for _____ _____
(Name of Customer) (Customer ID)

I understand and agree to the following:

1. To use the assistance payment to obtain shelter, food, clothing, etc. for the customer.

2. To provide some accounting so that the local department can know how the money was used.

3. To the best of my ability, assist the customer in meeting daily needs; help with ongoing problems, and to maintain a close contact with the customer.

4. To report to the local department any change in the financial circumstances of the customer of which I am aware; or any change in my relationship to the customer.

_____ _____
Representative Payee Date

_____ _____
LDSS Case Manager's Signature Date

SECTION II REHABILITATIVE RESIDENCE OR CARE HOME CERTIFICATION

See Section III for Assisted Living placements

The above-named client has been approved for service and will be placed in a CARE Home or Rehabilitative Residence facility.

Facility: _____

Address: _____

Telephone No: _____

Service Eligibility has been established for: _____

Level of Care: _____

Planned Placement Date: _____

Mail Check to: _____

Address: _____

Placement approved by: _____

SECTION III MEDICAL REPORT

(Section III must be completed for PAA-Assisted Living applicants/recipients. This section also may be used for CARE Homes and Rehabilitative Residence applicants when an agency determination of need is not available.)

The information provided on this form may be used to determine eligibility for federal and state programs using Social Security disability criteria.

Please Print or Type

PATIENT INFORMATION:

Is a protective living arrangement necessary? ☐ **Yes** ☐ **No**
If yes, Justification for Protected Living Arrangement on page 3 must be completed

Name of Patient: _____ Date of Birth: _____

Name of Licensed Professional or Physician: _____

Address: _____

Specialty: _____

Phone: _____

Dates of Examination: First Visit: _____ Last Visit: _____

Presenting Symptoms:

_____

_____

_____

Diagnosis**:** _____ Onset Date: _____

Diagnosis: _____ Onset Date: _____

Hearing Limitations ☐ Yes ☐ No ☐ Minimal ☐ Moderate ☐ Extreme ☐ Severe

Speaking Limitations ☐ Yes ☐ No ☐ Minimal ☐ Moderate ☐ Extreme ☐ Severe

MENTAL HEALTH

Does the patient suffer from mental illness? ☐ Yes ☐ No

_____

_____

_____

To the best of your knowledge does the patient exhibit any violent behaviors? ☐ Yes ☐ No

If yes, list below

_____

_____

SECTION IV VISUAL LIMITATIONS

Visual Field: OD _____ OS _____ VA _____

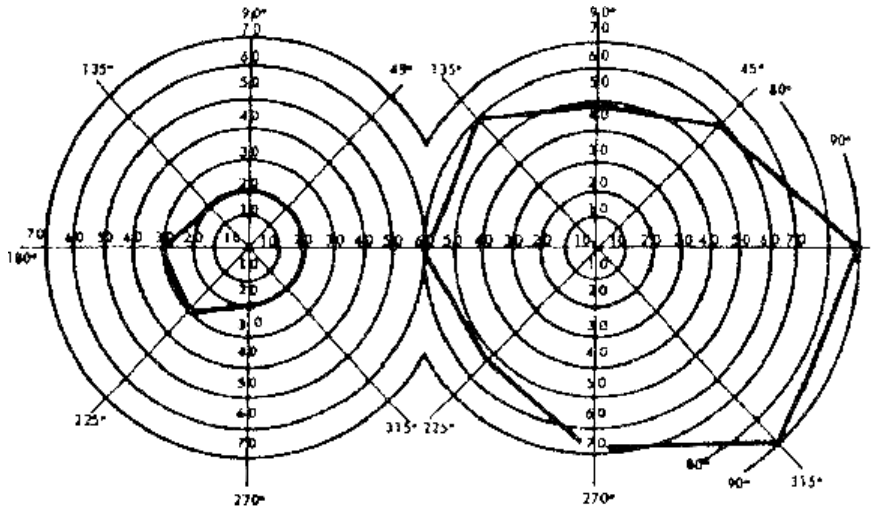
(After corrections): OD_____ OS _____ VA _____

PROGNOSIS AND RECOMMENDATIONS

Patient's vision impairment LEVEL (**PLEASE INDICATE BELOW**)

Stable _____ Deteriorating _____ Capable of Improvement_____ Uncertain_____

Other recommendations (e.g., special eye consultation, special medical examination, low-vision aide, mobility training, prostheses, etc.; explain):



Justification for Protected Living Arrangement:

_____
_____
_____
_____

Additional Comments:

_____
_____
_____
_____

Signature: _____ Print Name: _____

Title: _____ Telephone: _____

License or Federal ID#:_____

MA Provider#: _____ Date: _____